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Policy Media Department | Brief

Rural Maternal Healthcare Access

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Abstract: Rural communities across the United States face persistent disparities in maternal healthcare access, driven by hospital closures, shortages of obstetric providers, geographic isolation, and financial barriers. This brief examines the consequences of these disparities and evaluates policy interventions, including sustained funding for rural labor and delivery units, expanded local prenatal and postpartum services, and improved access to private well-water testing. It argues that addressing rural maternal health requires strengthening existing healthcare infrastructure while making essential services more accessible to underserved communities.

Keywords — **Rural maternal healthcare; maternal health disparities; environmental health; healthcare infrastructure**

I. Executive Summary

Access to maternity care in the United States is shrinking, and the strain is hardest on rural communities. As of 2026, 34.6 percent of U.S. counties are "maternity care deserts," meaning they have no obstetric clinicians or birthing facilities. These counties are home to 2.4 million women of reproductive age and 149,000 births each year, and an additional 3.4 million women live in counties with only low or moderate access. Women in these areas travel about three times farther for labor and delivery care than women in counties with full access, and 19 more maternity services had closed or announced closures by August 2026 (Jeffries, 2026). Consequently, the National Rural Health Association 9NRHA) reported an increasing difference in maternal morbidity and mortality between women in rural and urban areas (Harrington et al., 2023). This brief examines how rural maternal healthcare access has declined, who is affected, and what risks follow if policymakers do not act. It then weighs policy options and their likely impact on maternal health to inform a path toward safer pregnancies and deliveries for rural families.

II. Overview

Disparities in maternal healthcare access heavily affect women living in rural areas in the United States. Many rural areas have fewer healthcare facilities that offer obstetric services due to closures from financial strain. In 2022, 52.4% of rural hospitals did not offer obstetric healthcare, while only 35.7% of urban hospitals did not offer obstetric healthcare. Rural areas also do not have enough providers qualified to give sufficient care to mothers, with family physicians often providing care instead of obstetricians and midwives. One study has shown that there are fewer obstetricians and advanced practice midwives per woman of childbearing age in rural areas than urban areas, but there are more family physicians who deliver babies in rural areas than urban areas.

Counties that do not have hospitals with obstetric services, birth centers, or obstetric clinicians are called Maternity Care Deserts (MCDs). The nonprofit organization March of Dimes found that over a third of U.S. counties (34.6%) are MCDs.

Transportation, insurance, long distances, and financial issues are additional factors that can limit access to healthcare. Women in rural areas often have to drive 30 to 45 minutes, or even more to the nearest facility, which can increase the chances of premature delivery by 1.53 times. A study showed that rural women had higher rates of uninsurance than urban women during prepregnancy, at birth, and postpartum. Health knowledge and health status before a woman gets pregnant can also impact outcomes. Studies have shown that rural women are more likely than urban women to have poor nutrition and diet, unhealthy weight, lack of vaccines, and history of substance use.

Maternal healthcare is extremely important to the health of a mother and an infant. Physical and mental care is necessary before, during, and after pregnancy. Without care, the chances of mortality and morbidity of mothers and infants increase. Premature or unplanned births, low birthweight, and postpartum depression are just a few of the outcomes that may occur due to lack of maternal care. The Pregnancy Mortality Surveillance System reports that in 2024, the rate of pregnancy-related deaths was highest in rural areas compared to suburban and urban areas. Another study found that from 2021 to 2023, the total infant mortality rate was highest in rural areas compared to small, medium, and large metropolitan areas.

In order to reduce these disparities and ensure that mothers and infants are getting adequate care, policymakers must identify areas for improvement and take action.

III. History

A. Current Stances

Disparities in healthcare access between rural and urban areas have existed since the 20th century. Organizations like the American Public Health Association focused on improving city hygiene and safety starting in 1872. But sanitation and immunization in rural areas was stagnant. Infectious disease outbreaks were common in these areas, but did not receive much attention due to the small number of deaths in comparison to cities.

Efforts to improve maternal and infant healthcare were also mainly focused on urban areas, leaving rural areas with increased infant mortality rates while urban areas experienced a decrease. The maternal mortality rate in 1915 was 607.9 per 100,000 live births. One in ten infants did not reach a year in age. Economic hardships often forced rural women to work, even if they were pregnant. The majority of women also did not have access to prenatal healthcare and education, with little to no hospitals or physicians. Heavy snow and other extreme weather events also prevented physicians from traveling long distances to care for mothers and infants.

Rural areas still face widening disparities in the 21st century, especially in maternal healthcare. The COVID-19 pandemic worsened many of the challenges rural hospitals were already dealing with, such as staff shortages, limited access to resources,

and decreases in infrastructure quality. In 2004, 46% of rural counties did not have access to obstetric services. By 2018, it had risen to over 56%.

Rural hospitals have gotten increasingly more vulnerable to closures. Between 2010 and 2024, over 171 rural hospitals closed. In 2024, 420 rural hospitals were at risk of closure. More than 50% of them were operating at negative margins. As of late October 2026, almost 700 hospitals– almost a third of all rural hospitals– are at risk of closure. The National Rural Health Association White Paper estimated that if every vulnerable rural hospital were to close, 11.7 million people would have significant challenges accessing healthcare.

B. Tried Policy

49 states and the District of Columbia have extended Medicaid coverage for postpartum care up to 12 months, since Medicaid covers 47% of rural births. However, recent Medicaid cuts are likely to make access to care more difficult. Providing paid leave can also support maternal health during postpartum recovery. Yet, in 2021, only 31% of rural municipalities had paid maternity leave, compared to 41.2% of urban municipalities.

Telehealth expansion, such as remote monitoring and virtual consultations, is another option that is being considered to reduce the burden of long distance travels. However, some insurance and Medicaid programs do not cover virtual consultations as much as in-person visits. Some states also do not allow providers to prescribe medications online. Telehealth can also be limiting in terms of physical exams and tests.

In 2022, the U.S. Health Resources and Services Administration created Maternity Care Target Areas. This system identifies areas that have shortages of maternity care professionals and evaluates how much direct federal support is needed through a 0-25 score system. The Center for Disease Control and Prevention also implemented a "birthing-friendly" hospital and health system designation, which identifies hospitals that provide high-quality maternal healthcare. However, both of these systems only identify the lack of maternal healthcare, instead of directly addressing it.

IV. Policy Problem

A. Stakeholders

There are several stakeholders involved in access to maternal health care, including hospitals, insurance companies, policymakers, legislators, and rural patients and communities.

Nearly 94% of the U.S. population lives within 30 minutes of an obstetric hospital. However, this number decreases to 86% in maternity care deserts. To put it into perspective, women might have to travel as far as 28.1 miles in maternity health deserts and 17.3 miles in rural counties. A lot of the nearest hospitals are inevitably in rural areas, which have seen a much higher maternal morbidity rate compared to their urban counterparts at 65% in hospitals with 10-110 births per year, 37% higher with 111-140 births per year, and 26% higher in hospitals with 241-460 births per year. These figures show how fewer births per year in hospitals greatly reduces the resources hospitals have available for obstetric care. If birth rates are low enough, hospitals may have no choice but to close down their obstetric care facilities. This situation is further

compounded by the fact that insurance companies tend to offer lower reimbursement rates for hospitals in rural areas than in urban ones, further reducing the resources available to hospitals. If the hospital does decide to close down, research has shown a slight increase in births outside of the hospital, a large increase in emergency department births, and a modest increase in preterm birth, which is associated with infant mortality. This worsens an already problematic trend of limited healthcare access in these rural communities. Policy should include volume thresholds for safety and quality, or define a minimum number of births needed for hospitals to offer obstetric services safely. About 200 births are needed for an obstetric unit to be financially stable and safe, according to a survey.

B. Risks of Indifference

Rural communities without access to obstetric care units also faced reduced availability of preterm mental health services, postpartum and breast feeding support groups, and fewer opportunities for lactation advice and help from clinical experts. This is particularly problematic considering that mothers in maternal care deserts tend to be at higher risk for postpartum depression compared to mothers who have more access to care. Being far away from the necessary care, as well as being isolated from support which might be necessary in such a transitory state of life, opens up the possibility of mental health diagnoses going undiagnosed and untreated.

There is also the added component that the closure of a great number of hospitals will only further increase the travel time the mother will have to make to get care.

V. Policy Options

A. Annual Funding for Rural Labor and Delivery Units

States could allocate rural hospitals annual payments to keep labor and delivery units open. A hospital, even when it only delivers a few babies in a month, needs trained staff and working equipment to carry out essential procedures (Kozhimannil et al., 2024).

A main concern remains whether smaller hospitals can safely handle emergencies. To approach this issue, states could tie a hospital's funding to staffing and its emergency readiness and prioritize hospitals where closure would cause families much longer drives to a sufficient medical center and enforce maternity care deserts.

B. Local appointments and Longer Postpartum Coverage

Rural clinics could partner with larger hospitals so patients can get routine prenatal and postpartum care closer to their home and see necessary specialists through telehealth. An established federal program already supports this approach by "building networks to coordinate continuum of care," but it only funds selected regional networks (Health Resources and Services Administration 2026). To help more rural clinics offer these services, private insurers could share upfront costs such as video equipment, internet upgrades, and staff training. States could review Medicaid reimbursement rates and raise them in areas where payments fall short of what it costs rural providers to offer such visits. (Kozhimannil et al., 2024).

Getting an appointment nearby is beneficial if patients can afford it. States can extend Medicaid and CHIP coverage to 12 months after a pregnancy so eligible patients can keep their insurance and

keep receiving follow-up care throughout the first year, which addresses postpartum health that the mother would normally not receive (Centers for Medicare & Medicaid Services 2024).

C. Free Well-Water Testing through Prenatal Clinics

County health departments could give prenatal clinics free testing kits for patients that obtain their water from private wells. Farm runoff can introduce nitrates into well water, and the CDC recommends that families test the water when someone in the household becomes pregnant (Centers for Disease Control and Prevention 2024).

Testing would inform families whether there is a problem, however some may struggle to pay for safe water. Counties could offer temporary drinking water assistance while families address contamination.

VI. Impact on Maternal Health

Environmental exposure also threatens maternal health in rural communities, particularly women whose primary source of drinking water is private wells. Agricultural runoff often results in harmful contaminants, such as nitrates, entering groundwater. Such contaminants pose dramatic health risks for mothers and their infants. Because private wells are not required to be routinely monitored, families in rural areas are at a greater risk of consuming water that is unknowingly polluted. An increased exposure to nitrates during pregnancy often results in perinatal complications, such as preterm birth and various birth defects. These environmental risks pose a greater danger to expecting mothers in rural areas as the lack of access to prenatal healthcare makes it more difficult for them to identify and address potential health complications. Consequently, environmental exposure contributes to existing maternal health disparities between rural and urban communities.

VII. Conclusions

Rural mothers in the United States are losing access to maternity care when needed most. More than a third of U.S. counties are now maternity care deserts, and nearly 700 rural hospitals are at risk of closure. Each obstetric unit that shuts down means longer drives, more births in emergency departments, and more preterm deliveries. Women in these areas also don't receive prenatal visits, postpartum mental health support, or lactation care, leaving conditions such as postpartum depression undiagnosed and untreated.

Annual funding tied to staffing and emergency readiness can keep labor and delivery units open. Partnerships between rural clinics and larger hospitals, backed by telehealth investment and adequate Medicaid reimbursement, will bring routine prenatal and postpartum visits closer to home; twelve months of postpartum Medicaid and CHIP coverage would help patients afford those visits. Free well-water testing through prenatal clinics is a low-cost way to address an environmental risk that rural households face.

Medicaid pays for nearly half of rural births, and recent cuts threaten that coverage, so the cost of doing nothing is growing. If policymakers act now, where a mother lives will no longer decide whether she and her baby can thrive safely.

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